Little Friends Daycare enrollment
Information and Authorization forms

Health Information

Name of Child's Physician?:_____ Phone #:_____

Address:_____ Name of Clinic?_____

Name of Child's Dentist?:_____ Phone #:_____

Address:_____ Name of Clinic?_____

Does your child have any allergies or serious medical conditions we need to know about?

If yes, Please explain:_____

Is your child recieving any medication?_____

Please check if your child has been immunized for the following:

Polio:____ Chicken pox:_____ Scarlet fever:_____ mumps:_____ measles:_____

German Measles:_____ Flu:_____ Hep A:_____ Hep B:_____

PLEASE PROVIDE IMMUNIZATONS RECORDS

Does your child get frequent colds or ear infections?_____

MEDICAL AUTHORIZATION

____ I do not want my child to receive any medical treatment without my knowledge or consent.

____ I Authorize Little Friends Daycare/or Caregiver there to seek Medical Treatment by calling an ambulance or taking my child to any Physician or Hospital at my expense if I cannot be reached.

My Medical Insurance is with: _____ Group#_____

ID #_____ Mothers SS#_____ Father's SS#_____

DEVELOPMENTAL INFORMATION

Other Children in the household

Name:_____ Birthday_____ relationshiop:_____

Name:_____ Birthday:_____ Relationship:_____

Name:_____ Birthday:_____ Relationship:_____

Other Adults in household

Name:_____ Relationship:_____ Name:_____ Relationship:_____